CAI-2007-33

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

COAL MINE SAFETY AND HEALTH

REPORT OF INVESTIGATION

Surface Coal Facility

Slip or Fall of Person
November 4, 2007
(Victim Died January 2, 2008)

Remington Preparation Plant
Weatherby Processing Corp.
Ohley, Kanawha County, West Virginia
MSHA I. D. 46-08685

Accident Investigators

James R. Humphrey
Coal Mine Safety and Health Inspector

Edward O. Matthews
Coal Mine Safety and Health Inspector

Originating Office
Mine Safety and Health Administration
100 Bluestone Road
Mount Hope, West Virginia 25880
Robert G. Hardman, District Manager

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PHOTOGRAPH OF ACCIDENT SCENE

OVERVIEW

At approximately 7:35 a.m., on Sunday, November 4, 2007, 42-year old Larry W. Bird, floor walker/mechanic fell from the third floor of the preparation plant to the ground floor. Bird passed away on January 2, 2008 while hospitalized for injuries received in the accident. Bird had 17 years of experience at a surface facility and was employed at this operation and activity for 3 years and 3 months. The accident occurred while an 8-inch diameter recirculating media pipe, located above the third floor walkway, was being replaced. During the replacement, Bird dropped a 28-volt battery-powered impact wrench. The impact wrench landed on a 6-inch horizontal ledge located along the wall of the preparation plant. While attempting to retrieve the impact wrench, Bird crossed beyond the third floor handrail without fall protection and fell to the ground floor.

GENERAL INFORMATION

The Weatherby Processing Corp., Remington Preparation Plant is located near Ohley, in Kanawha County, West Virginia. The 550 ton-per-hour facility employs 33 persons and operates two 12 hour shifts each 24 hours, 7 days a week. The employees are divided into 4 crews, A-Crew, B-Crew, C-Crew and D-Crew, which work a 4 day on and 4 day off rotation. The crews do not switch shifts. The facility operates 5 to 6 days a week depending on the amount of raw coal available, and maintenance is performed on Sundays.

The principal officers for Weatherby Processing Corp.

Paul Vining……..…….……President
Keith St. Clair…….…….Secretary & Treasurer
Donald Suddreth…….Operations Manager, Magnum Coal Company
Frank Foster……Corporate Director of Safety, Magnum Coal Company
Randy Boggs……Safety Director, Weatherby Processing Corp.
Charles Dorsey……...……Superintendent, Weatherby Processing Corp.

The last MSHA inspection of this facility was completed on February 5, 2007. The Non Fatal Days Lost (NFDL) incidence rate in 2007 was 0.00, compared to the national average of 1.87 for facilities of the same type.

DESCRIPTION OF THE ACCIDENT

On Sunday, November 4, 2007, at approximately 5:45 a.m., Gregory Williams, foreman of the C-Crew, gathered his crew of 5 men and held a safety meeting. The safety topic for the week of November 4, 2007 was "Avoiding Slip and Trip Injuries." Once the safety meeting was completed, the attendees were required to sign the final page of the prepared safety topic. The document was then maintained at the mine site by the safety director. The safety meeting lasted approximately 15 minutes.

Once the safety meeting was completed, Williams then reviewed a maintenance list and made assignments. Trinel Simpkins, floor walker/mechanic, was assigned to change out a section of the recirculating media pipe located over a cat walk on the third floor, which was an 8-inch diameter pipe, approximately 40-inches in length. Larry W. Bird, floor walker/mechanic and victim, was assigned to work with members of a contractor, Process Construction, on the fourth floor of the facility changing the route of a 16-inch pipe that runs from the baby cyclones to the thickener.

Simpkins traveled to his work location on the third floor. Bird joined Williams and Douglas Belcher, lead foreman for the contracting crew, and traveled to the work

location on the fourth floor. Williams checked the area of the job site on the fourth floor. Williams then traveled to the third floor where Simpkins had already started removing bolts from a flanged pipe coupling then continued to the office, which is located next to the plant facility.

Stanley Pomeroy, dozer operator, was working inside the facility replacing a short piece of 6-inch pipe in another area of the third floor. Pomeroy called Bird on a two-way radio, carried by all employees, requesting Bird to measure a length of pipe to be cut. Bird called Pomeroy and gave him the measurement. Bird also asked Pomeroy to get his welding bag out of the change clothes room and bring it when he returned with the 6-inch pipe.

Bird and Belcher traveled to the third floor where Simpkins was working. Bird assisted Simpkins while Belcher traveled back to the parking lot to check whether his work force had reported to work. Bird and Simpkins removed the bolts from each flanged end of the pipe (four bolts to each flange). The 40-inch section of pipe would not drop free from the remaining pipe. A large wrench was used to tap the joint of pipe but the pipe remained firmly in place. Bird retrieved a battery-powered impact wrench and loosened the nuts on one of the Morris Coupling that was supporting a short 8-inch pipe between the two flanged-end pieces.

As the nuts were loosened, the 40-inch section of pipe flexed slightly (twisted) and then dropped free. When the 40-inch section of pipe flexed, the socket on the impact wrench became separated from the wrench. The impact wrench was dislodged from Bird's hand. The 40-inch section of pipe and the socket fell to the first floor of the preparation plant. The impact wrench landed on a 6-inch channel that extended horizontally along the outer wall of the preparation plant. Neither the 40-inch section of pipe nor the impact wrench struck Bird or Simpkins.

An open area measuring 3.4 feet existed between the walkway and the 6-inch channel where the impact wrench laid. The channel was 1.8 feet below the floor of the third floor walkway. The floor of the walkway on the third floor was 19.4 feet above the first floor. A standard 42-inch high steel handrail (guard) was securely in place along the entire length of the open side of the walkway. The center railing was 2 feet above the walkway and the toe plate extended 5-inches above the walkway.

Bird and Simpkins discussed the situation and decided that Simpkins would travel to the first floor to retrieve the pipe and socket while Bird would retrieve the impact wrench from the channel. Simpkins left Bird standing on the walkway and traveled to the west side of the building to reach the stairs. At approximately 7:30 a.m., Simpkins, traveling past the fine refuse effluent sump of the second floor, caught sight of something falling from above to the first floor. Simpkins ran to the railing on the second floor and saw Bird lying on the first floor. Simpkins shouted out to

Bird but received no response. Simpkins called for help on his radio. Pomeroy, cutting a piece of pipe on the first floor, heard Simpkins calling out and responded. Pomeroy was the first person to reach Bird finding him lying face down on the concrete floor, unresponsive.

Pomeroy administered first aid and with co-workers, removed Bird from the preparation plant. Kanawha County Emergency Ambulance Service arrived at the site and transported Bird to Charleston Area Medical Center located in Charleston, West Virginia.

INVESTIGATION OF THE ACCIDENT

The Mine Safety and Health Administration (MSHA) was notified of the accident at 7:35 a.m. on Sunday, November 4, 2007. MSHA personnel were immediately dispatched to the mine site. A 103(k) order was issued to insure the safety of all persons during the investigation. The accident scene was photographed, sketched, and surveyed. Interviews were conducted of persons considered to have knowledge of the facts concerning the accident. A list of the persons who participated in the investigation is shown in Appendix A.

The investigation was conducted with the cooperation of the West Virginia Office of Miners' Health, Safety and Training (WVOMHST), the mine operator, and the mine employees.

DISCUSSION

Physical Conditions of the Work Site

The walkway at the work site on the third floor was in good condition. A standard securely anchored handrail existed along the entire length on the open side of the walkway. The top steel rail of the handrail structure measured 42 inches above the floor of the walkway. The center railing and tow plate were 2 feet and 5 inches above the walkway, respectively. An open area existed between the walkway and the exterior east wall of the preparation plant measuring approximately 18.2 feet in length and 3.4 feet in width. The distance from the walkway of the third floor to the floor of the first floor measured 19.4 feet. The distance from the 6-inch channel that the impact wrench fell onto and the toe guard of the walkway measured 3.4 feet. The 6-inch channel was 1.8 feet below the surface of the third floor walkway.

The 8-inch diameter high density polyethylene pipe being removed was approximately 40 inches in length and weighed approximately 80 lbs. The pipe extended horizontally from north to south and was 6.5 feet above the walkway.

Fall Protection

Seven full body harnesses of various sizes were located at different locations throughout the plant facility. A safety meeting was held prior to the start of the shift. The topic of the safety meeting was "Avoiding Slip & Trip Injuries." All plant personnel attended the meeting prior to beginning of their work day.

Training

Information gathered during the investigation revealed that "Fall Protection" and "Securing Objects from Falling" was not covered in the mine operator's Part 48 training plan. An addendum to the Part 48 training plan was submitted to include the topics of "Fall Protection" and "Securing Objects from Falling" during Newly Employed Training, Annual Retraining, Hazard Training and Contractor Training.

ROOT CAUSE ANALYSIS

A root cause analysis was conducted to identify the most basic causes of the accident that were correctable through reasonable management controls. Listed below are root causes identified during the analysis, and their corresponding corrective actions were implemented to prevent a recurrence of the accident.

Root Cause: A safe procedure, using fall protection, was not followed in retrieving the impact wrench. The victim could only have fallen by climbing over or through the railing. The victim was not wearing fall protection.

Corrective Action: The mine operator submitted an addendum to the Part 48 training plan on November 6, 2007. The addendum addresses the use of fall protection where persons are working in surface installations through which persons may fall. The addendum will be incorporated in all Newly Employed Training, Annual Retraining, Hazard Training, and Contractor Training.

CONCLUSION

The accident occurred because a safe work procedure was not followed. The victim traveled beyond the handrail guarding without fall protection and fell 19.4 feet to the first floor. The victim passed away January 2, 2008, due to injuries sustained during the accident.

Approved by:

Robert G. Hardman
District Manager

04/18/2008
Date

ENFORCEMENT ACTIONS

1) A 103(k) Order, No. 7274122 was issued to ensure the safety of the miners until the investigation could be completed.

2) A 104(a) Citation, No. 7281415, was issued for a violation of 30 CFR 77.1710(g), stating: An employee working in a surface work area did not wear protective clothing and devices such as safety belts and lines where there was danger of falling.

   An accident occurred November 4, 2007, causing fatal injuries. The victim did not obtain and use protective devices to prevent him from falling from an elevated area on the east side of the preparation plant. The victim fell 19.4 feet from the walkway of the third floor to the floor of the first floor. The victim passed away January 2, 2008, due to the injuries received during the accident.

APPENDIX A
Persons Participating in the Investigation

Weatherby Processing Corp

Randy Boggs……..…..Safety Director
Charles Dorsey……..Superintendent
Gregory L. Williams……...….Shift Foreman
Charles Slone……Shift Foreman
Trinel Simpkins……..……Floor Walker/Mechanic
Richard H. Parsons…….….Scale House Attendant
Stanley Pomeroy…….…..Dozer Operator

Process Construction Inc.

Howell Douglas Belcher……..……Foreman

Magnum Coal Company

Frank Foster…….……Corporate Director of Safety
Donald Suddreth……..Operations Manager

West Virginia Office of Miner's Health, Safety and Training

Steve Snyder…….……Inspector-at-Large
Bill Tucker……...….Assistant Inspector-at-Large
Jerry Pauley…….……Underground Inspector
Clarence Dishman……..Underground Inspector

Mine Safety and Health Administration

Fred Wills……Supervisory CMS&H Inspector
Marty Carver…….CMS&H Inspector
Edward Matthews……CMS&H Inspector
James R. Humphrey…….CMS&H Inspector

APPENDIX B
Victim Information

Accident Investigation Data - Victim Information
Event Number: 4 1 1 5 5 8 3

U.S. Department of Labor
Mine Safety and Health Administration

Victim Information: 1

1. Name of Injured/Ill Employee:	2. Sex	3. Victim's Age	4. Last Four Digits of SSN:	5. Degree of Injury:
Larry W. Bird	*M*	*42*		*01 Fatal*

6. Date(MM/DD/YY) and Time(24 Hr.) Of Death: *a. Date: 01/02/2008 b.Time: 10:05*

7. Date and Time Started: *a. Date: 11/04/2007 b.Time: 6:00*

8. Regular Job Title: *104 Floor Walker/Mechanic*

9. Work Activity when Injured: *048 Mehcnaic In Plant*

10. Was this work activity part of regular job? Yes | X | No

11. Experience	Years	Weeks	Days		Years	Weeks	Days		Years	Weeks	Days		Years	Weeks	Days
a. This Work Activity:	*17*	*0*	*0*	b. Regular Job Title:	*17*	*0*	*0*	c: This Mine:	*3*	*12*	*0*	d. Total Mining:	*17*	*0*	*0*

12. What Directly Inflicted Injury or Illness? *002 Fell 24 feet*

13. Nature of Injury or Illness: *290 Bilateral Consolidating Pneumonia*

14. Training Deficiencies:
Hazard: | | New/Newly-Employed Experienced Miner: | | Annual: | | Task: | |

15. Company of Employment:(If different from production operator) *Operator*

Independent Contractor ID: (if applicable)

16. On-site Emergency Medical Treatment:
Not Applicable: | | First-Aid: | X | CPR: | | EMT: | | Medical Professional: | | None: | |

17. Part 50 Document Control Number: (form 7000-1)

18. Union Affiliation of Victim: *9999 None (No Union Affiliation)*

Victim Information:

1. Name of Injured/Ill Employee:	2. Sex	3. Victim's Age	4. Last Four Digits of SSN:	5. Degree of Injury:

6. Date(MM/DD/YY) and Time(24 Hr.) Of Death:

7. Date and Time Started

8. Regular Job Title:

9. Work Activity when Injured:

10. Was this work activity part of regular job? Yes | No

11. Experience:	Years	Weeks	Days		Years	Weeks	Days		Years	Week	Days		Years	Weeks	Days
a. This Work Activity:				b. Regular Job Title:				c: This Mine:				d. Total Mining:			

12. What Directly Inflicted Injury or Illness?

13.Nature of Injury or Illness:

14. Training Deficiencies:
Hazard: | | New/Newly-Employed Experienced Miner: | | Annual: | | Task: | |

15. Company of Employment: (If different from production operator)

Independent Contractor ID: (if applicable)

16. On-site Emergency Medical Treatment:
Not Applicable: | | First-Aid: | | CPR: | | EMT: | | Medical Professional: | | None: | |

17.Part 50 Document Control Number: (form 7000-1)

18. Union Affiliation of Victim:

Victim Information:

1. Name of Injured/Ill Employee:	2. Sex	3. Victim's Age	4. Last Four Digits of SSN:	5. Degree of Injury:

6. Date(MM/DD/YY) and Time(24 Hr.) Of Death:

7. Date and Time Started:

8. Regular Job Title:

9. Work Activity when Injured:

10. Was this work activity part of regular job? Yes | No

11. Experience:	Years	Weeks	Days		Years	Weeks	Days		Years	Week	Days		Years	Weeks	Days
a. This Work Activity:				b. Regular Job Title:				c: This Mine:				d. Total Mining:			

12. What Directly Inflicted Injury or Illness?

13. Nature of Injury or Illness:

14. Training Deficiencies:
Hazard: | | New/Newly-Employed Experienced Miner: | | Annual: | | Task: | |

15.Company of Employment:(If different from production operator)

Independent Contractor ID: (if applicable)

16. On-site Emergency Medical Treatment:
Not Applicable: | | First-Aid: | | CPR: | | EMT: | | Medical Professional: | | None: | |

17. Part 50 Document Control Number: (form 7000-1)

18. Union Affiliation of Victim:

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